Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UT SOUTHWESTERN MEDICAL CENTER
ST PAUL UNIVERSITY HOSPITAL
P O BOX 849928
DALLAS TX 75284 9928

Respondent Name

HARTFORD FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-2561-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed please find our Amended Request for Medical Dispute Resolution based on the Contested Case Hearing decision." "Attached please find a copy of the Contested Case Hearing decision date January 31, 2010 which found for the claimant,…'the May 20, 2006 compensable injury includes or extends to include cellulitis, staph infection, and abscesses.'"

Amount in Dispute: $53,837.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier pd $9326.65 which is an overpayment of $42.90 per 3/1/08 TX Medical Fee Guidelines Rule 134.404(f)(1)(A). Please see attached evidence of payment."

Response Submitted by: Hartford Fire Insurance Company, 200 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2008 Through June 2, 2008	Inpatient Hospital Surgical Services	$53,837.49	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.

3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 17, 2008
   - W12 –EXTENT OF INJURY NOT FINALLY ADJUDICATED. REIMBURSEMENT WITHHELD – CHARGE UNRELATED TO INJURY.

   Explanation of benefits dated February 16, 2011
   - Payment History Screen shows reimbursement was made on February 17, 2011 under check number 116275863 that was paid by the bank on February 22, 2011.

Issues

1. Has the extent of injury issue been resolved?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The respondent denied disputed services with reason code W12 – "EXTENT OF INJURY NOT FINALLY ADJUDICATED. REIMBURSEMENT WITHHELD – CHARGE UNRELATED TO COMPENSABLE INJURY." A Contested Case Hearing was held on January 31, 2010 to address the extent of injury issues regarding the injured worker's compensable injury. The decision held, in pertinent part, that, "The May 20, 2006 compensable injury includes or extends to include cellulitis, staph infection, and abscesses." The Division finds that the extent of injury issue has been resolved; therefore, the services rendered to treat cellulitis, staph infection, and abscesses related to the compensable injury will be reviewed per applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:

   The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 603 is $6,522.13.

   This amount multiplied by 143% is $9,326.65.

   The total maximum allowable reimbursement (MAR) is $9,326.65.

   This amount less the amount previously paid by the respondent of $9,369.55 leaves an amount due to the requestor of $0.00.

   The Division concludes that the requestor is not entitled to additional reimbursement.

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Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		October 3, 2011
Signature	Medical Fee Dispute Resolution Officer	Date
		October 3, 2011
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.